Iowa Department of Human Services

Iowa State Innovation Model (SIM)
Metrics & Contracting Workgroup
Summary of Suggestions and Discussions

The recommendations included reflect the work of the Metrics & Contracting Workgroup and may not reflect the position of the Governor's Office and the Department of Human Services.

October 2013

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Executive Summary

The State of Iowa has been developing a State Health Care Innovation (SHIP) - the multi-year plan that ensures the State achieves its goals of lowering health care costs, improving the quality of health care for Iowans, and improving health outcomes for Iowans. Stakeholder engagement and involvement are core tenets of the State Innovation Model (SIM) grant that the State received from the Centers for Medicare and Medicaid Innovation and the State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process.

In order to ensure attention and feedback on the key strategies outlined in the original grant proposal and to support the State in developing a framework for the Accountable Care Organization (ACO) model, the State developed four workgroups, one for each key strategy. These workgroups are: Metrics and Contracting; Behavioral Health Integration; Long Term Care Supports and Services Integration; and Member Engagement. All workgroup meetings were open to the public and agendas and minutes were posted to the DHS website, as were other supporting resources.

Each workgroup met four times for two hours, over the course of two months. The first meeting was primarily focused on providing information to workgroup members about the project, the context and their roles. The next three meetings were focused on discussing and developing recommendations for transforming Iowa's health care system that would be considered for inclusion in state's SHIP.

This report provides a summary of the original reference report provided to the Metrics and Contracting Workgroup, and details about questions that were discussed in the meetings. Additionally, recommendations and suggestions generated by the Metrics and Contracting workgroup are included in this report.

Overview of Approach

The State of Iowa has been developing a State Health Care Innovation (SHIP) - the multi-year plan that ensures the State achieves its goals of lowering health care costs, improving the quality of health care for Iowans, and improving health outcomes for Iowans. Stakeholder engagement and involvement are core tenets of the State Innovation Model (SIM) grant that the State received from the Centers for Medicare and Medicaid Innovation and the State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process.

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These workgroups are:

- *Metrics & Contracting*: Chaired by Tom Evans, this workgroup was tasked with developing recommendations and goals around the structural arrangement of the ACOs, payment provisions and metrics and measures to use.
- *Behavioral Health Integration:* Chaired by Rick Schults, this workgroup discussed measures that should be used to ensure accountability for behavioral health care needs, considerations for including the safety net providers in any ACO arrangement and the importance of building upon the strengths of the Integrated Health Home and the current Iowa Plan and its additional services and focus on recovery.
- *Long-term Care Supports and Services Integration*: Chaired by Donna Harvey, this workgroup focused on the best approach to integrating these important services into the ACO model, what care coordination should look like and what types of measures will encourage and support increased use of home and community based services.
- *Member Engagement*: Chaired by Chris Atchinson, this workgroup was tasked with developing goals and recommendations about approaches to engaging members in their own care and encouraging them to be active participants in becoming healthier. There was also discussion about how to include and incorporate the strengths of the public health system in order to address population health and achieve the Governor's Healthiest State Initiative.

Each workgroup met four times for two hours. The meetings were held every other week during the weeks of: July 22, August 5, August 19 and September 2. All workgroups had appointees but were open to the public. Meeting materials were posted on the IME SIM website, including reading materials for work group members to read before meetings, meeting agendas and meeting minutes. Although the specific areas of focus differed, the workgroup meetings were arranged as follows:

- Workgroup meeting #1: Level setting with a focus on the entire project, the need for transformation, an introduction to the ACO concept, an overview of the regional approach which will be part of the ACO model, and use of a competitive procurement process which will included multiple steps, including a Request for Information and Request for Proposals

- Workgroup meeting #2: Analysis and discussion of what works in the system of focus (LTC, BH, etc.), what does not work, and the goals and visions for a transformed system. From these workgroups, four summary documents of the key themes identified in each workgroup were developed.
- Workgroup meeting #3: Focus on developing 10 to 12 recommendations. These recommendations were then sent to the workgroups for them to identify and select their priorities. They were also asked to provide additional recommendations which might not have been mentioned. These priorities were then compiled into a summary document and shared prior to the fourth workgroup.
- Workgroup meeting #4: Focus on discussing and refining the recommendations, and soliciting any additional recommendations. Members were also asked to comment on priorities and discuss whether they would shift any of the priorities after further thought.

Prior to the first meeting, the SIM team developed a reference report for each workgroup. The Metrics & Contracting workgroup paper discusses the goals of the ACO model, State initiatives already underway, and options being used in other states. At the end of the reference report there were a series of questions that guided the discussions during workgroup meetings 2, 3 and 4.

Report Purpose

This Metrics and Contracting Workgroup report provides a summary of the original reference report as well a summary of the workgroup discussions and suggestions. The recommendations included reflect the work of the Metrics & Contracting Workgroup and may not reflect the position of the Governor's Office and the Department of Human Services.

Overarching Principles and Goal

The Accountable Care Organization model provides an opportunity to transform Iowa Medicaid into a patient-centered system that provides more coordinated and integrated care, improves the patient experience of care, achieves better health outcomes, and reduces cost by coordinating care, providing services in the right place at the right time and reducing inappropriate utilization (for example, non-emergent use of emergency rooms and avoidable hospital readmissions). IME's overall vision is to implement a multi-payer ACO methodology across Iowa's primary health care payers.

Iowa's goal for the SIM project is to create delivery system change and payment reform that reduces the rate of growth in health care costs for the state as a whole to the Consumer Price Index within three years. Once the ACO model has been developed and implemented, the goals of the ACO organization(s) are more aggressive: to reduce costs by 5%-8% within three years.

Current ("As Is") State

Demographics of Iowans

In year 2012, Iowa was home to 3,074,186 people. About 93% of Iowa residents are white (compared with 78% nationally), 3% are black (13% nationally), 0.5% are American Indian or

Alaska Native (1.2% nationally), and 5.2% are Hispanic (17% nationally).[1] About 36% of Iowans live in rural areas, compared with only 21% nationally[2].

In terms of age, Iowans closely resemble national averages, with the exception of having a higher percentage of the population who are 55 years old or older.

According to the Iowa state health fact sheet produced by the Kaiser Commission on Medicaid and the Uninsured, in 2011, percentages of people living in poverty in Iowa were slightly lower than percentages nationally. For example, about 13% of Iowans were in poverty (below 100% of the Federal Poverty Level, or FPL), compared with 20% for the U.S. Another 8% were living at 100-138% FPL, the same rate for the United States[3]. About 17.3% of Iowa's children were living in poverty, compared with 23% for the U.S. About 12.4% of adults ages 19-64 were living in poverty, compared with 15% of adults nationally, and 6.9% of Iowa's elderly were in poverty, compared with 9% nationally[4].

Health of Iowans

According to an assessment done by the Commonwealth Fund, Iowa's overall health ranking was 2nd in the country, previously ranked 3rd by the same report. This report analyzed 35 total indicators of health, in the categories of access, prevention and treatment, avoidable hospital use and costs, equity, and healthy lives. Iowa has a relatively high rate of insurance comparatively, ranking 2nd in the nation of children insured and 6th in the nation of adults insured. However, Iowa has a relatively low percentage of their population accessing preventative health services, with only 42.9% of adults accessing recommended primary care and preventative services. Iowa also received a low ranking in the category of heath equity, with disparities especially high between income and racial and ethnic groups, with 68.5% of low-income adults not accessing recommended primary care, about 25% higher rate than the overall state total. However, according to this report, overall health in Iowa is improving, and the state's ranking for 28 of the 35 indicators either stayed the same or improved[5].

The percentage of adults in Iowa who are obese (29%) is slightly higher than the national average (27.8%), while the percentage of children is Iowa who are obese is slightly lower (10.2% compared to the national average of 13%). Adults in Iowa use tobacco at very slightly lower rates than the national rates (20.4% versus 21.1%), with youth tobacco use mirroring the national rate at 18.1%. Nearly 83% of adults in Iowa do not meet physical health recommendations (compared with 79% nationally), while only 48.5% of youth do not meet these recommendations (compared with 50.5% nationally). Adult diabetes rates are slightly lower than the national average.

In Iowa, more adults have a usual source of care and more children have a medical home. Preventable hospital admissions are lower than the national average, for both adults and children, as are avoidable uses of the Emergency Room.

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[1] U.S. Census Bureau; American Community Survey. (2011). *Iowa State Quick Facts .*
[2] Ibid.
[3] Kaiser Family Foundation http://kff.org/other/state-indicator/distribution-by-fpl/
[4] U.S. Census Bureau; American Community Survey . (2011). *Selected Characteristics of People at Specific Levels of Poverty.* U.S. Census Bureau.
[5] Commonwealth Fund. (2009). Scorecard on Health System Performance. Commonwealth Fund.

Medicaid Enrollment and Expenditures

In 2009, Kaiser Family Foundation reported that total unduplicated enrollment throughout year was 522,746, with 152,008 adults and 250,287 children. About 16% of enrollees are adults, and 57% are children. With Iowa's population around 3 million, this suggests that approximately 17% of the state's population was enrolled in Medicaid at some point in 2009.[6] Using 2009 Medicaid enrollment numbers, the Kaiser Family Foundation reported that about 55% of Iowans were covered by employer-based insurance, 14% were enrolled in Medicaid, 13% were enrolled in Medicare, 6% had individual insurance, and 1% had other public insurance. The remaining 11% were uninsured, which is lower than the national average of 15.8%. Among those that are insured, 84% are covered by Wellmark, making it the largest insurer in Iowa. [7]

Iowa's spending on Medicare, which is $7,987 per person, is much lower than the national average, which is $9,477 per person. Although Iowa and the U.S. average spend a similar total amount per person for Medicaid, Iowa spends more on its aged and disabled populations, and less on its adult and child populations.

In 2012, while children represent about 57% of the Medicaid enrollment, spending on children was only 18% of Medicaid spending. Adults represent 16% of the enrollment numbers, but account for only 11% of the spending. As with other states and nationally, aged and disabled populations account for a large percentage of Medicaid spending. While only 19% of those enrolled are disabled, 50% of Medicaid spending was dedicated to this population. Only 8% of the Medicaid enrollees are aged, but they account for 21% of dollars spent[8].

Beneficiary Group	% of Medicaid Enrollees	% of Medicaid Spending
Children	57%	18%
Adults	16%	11%
Disabled	19%	50%
Aged	8%	21%

In FY 2010, Iowa spent close to $1.4 billion on long term supports and services. About 21% of the expenditures were for care for the 11,950 Medicaid enrollees in nursing facilities, while 38% was for care provided to the 25,624 Medicaid enrollees receiving care through a Home and Community Based Services Waiver. [9]

In terms of behavioral health care, about 4.9% of Iowans have a serious and persistent mental illness (SPMI), compared to the national average of 4.6%[10]. However, a lower percent of Iowans (30.6%) report having poor mental health, relative to the U.S. average of 35.8%. It is estimated that 25% of youth who need mental health services do not receive them.[11]

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[6] Kaiser Family Foundation http://kff.org/medicaid/state-indicator/medicaid-enrollment-as-a-of-pop-fy09/?state=IA
[7] State Health Access Data Assistance Center , 2012 pg. 10
[8] Iowa Department of Health and Human Services. *Improving Iowa's Health Status.* Iowa Department of Health and Human Services, 2012, p. 2
[9] http://kff.org/state-category/medicaid-chip/?state=IA
[10] Substance Abuse and Mental Health Services Administration. (2011). *National Survey on Drug use and Health.*Washington: U.S. Dept. of Health and Human Services, p. 4
[11] Kaiser Family Foundation http://kff.org/state-category/health-status/

Health Insurance and Other Care Delivery Systems in Iowa

Wellmark Blue Cross Blue Shield

Iowa's largest private insurance carrier is Wellmark Blue Cross Blue Shield, which covers about 1.8 million Iowans. In 2011, Wellmark began developing Accountable Care Organization arrangements with three health systems. Currently, Wellmark has ACOs operating across the state with the following health systems:

- Fort Dodge: UnityPoint Health
- Des Moines: UnityPoint Health; Mercy Medical Center
- Waterloo: UnityPoint Health, Wheaton Franciscan Healthcare
- Cedar Rapids: UnityPoint Health
- Davenport: UnityPoint Health, Genesis Health Systems

Over 250,000 Iowans are enrolled in these ACOs. The goals of these ACOs are to:

- ensure that care is patient-focused, and high quality;
- work with providers to slow the rate of increase in health care costs;
- reinforce and support local, physician-directed care; and
- improve health status through community transformation.

These ACOs are working to achieve these goals by providing better care coordination to improve health outcomes; ensuring that all appropriate care is received timely; patients are actively engaged in the care they receive and understand the costs; and, incenting and supporting participating providers' efforts in lowering costs without compromising care. By providing aligned incentives, providers are motivated to deliver value-based care versus volume based care. Providers are also supported with information about their patients that helps them provide better care coordination and more effectively identify enrollees who need additional attention and care coordination.

Wellmark shares cost savings that are realized through this improved care coordination with the ACOs. This sharing in cost savings is based on the ACO meeting certain quality targets. A total of 18 measures are used, and include measures of the patient's experience of care, the level to which prevention services are provided to patients, how well the providers coordinate care and provide follow-up care and care for chronic conditions, and the health of the population overall.

In the current Wellmark model, patients are linked up with (or "attributed to") a primary care provider (PCP). This happens in one of two ways. Most patients choose their PCP when they enroll in the ACO. When patients don't select a PCP, they are attributed to the PCP they have seen the most in the last 12 months, based on office visits called "Evaluation and Management services".

Other ACOs in Iowa

Trinity Pioneer ACO

The Trinity Pioneer ACO in Fort Dodge is one of 32 CMS Pioneer ACO Model sites in the United States, and is one of only two rural sites. Early data suggest that the Trinity Pioneer ACO is showing some successes. For example, hospital readmission rates dropped from 14%

in June 2012, to 9% in July 2012. Measures of patient satisfaction within the Pioneer ACO are higher than the national averages and are mostly higher than or equal to Iowa's state average.

Medicare Shared Savings Programs

Iowa also has Medicare Shared Savings Programs in Cedar Rapids, Des Moines, Quad Cities/Muscatine, and Waterloo. (Additional sites are just across the border in Peoria and Quincy, Illinois.) These programs have also shown early successes. For example, avoidable hospitalizations have been reduced among complex, chronically-ill patients by providing additional care, using Advance Medical Teams. Unnecessary emergency use has been reduced among patients with high emergency room use by engaging patients in their plan of care, connecting patients with medical homes, and involving social workers to coordinate health, medical and human service needs.

Future State ("To Be" State)

In order to meet the goals of transforming Iowa's Medicaid system, IME is proposing to build upon the Wellmark model and expand it to include more Accountable Care Organizations (ACOs) and more providers, and to cover Medicaid clients throughout Iowa. The new ACOs would be held to consistent performance metrics, which means that regardless of whether providers contract with Wellmark or the new ACOs (or both), the performance measures would be the same. Additionally, the new system and the Wellmark system would utilize the same or similar payment methodologies, including a standardized incentive for providers to be working toward the same result. One information technology platform will be used to support ACO management and tracking for providers. Emerging research is showing that this model can result in significant improvements in care coordination, care delivery, health outcomes, and reductions in cost of care as a result of avoiding unnecessary hospitalizations, use of emergency rooms, and other avoidable services.

The vision is to make the ACO system the primary care delivery system for nearly all Medicaid clients. A longer-term goal is to engage all payers, including health plans that serve CHIP enrollees and plans serving Marketplace Choice enrollees.

Examples of Successes and Lessons Learned

Several states have implemented ACOs, including North Carolina, Colorado, Vermont, and Oregon, and many lessons have emerged from the implementation of ACOs in other states.

- Allow for flexibility: States have learned that it may be helpful to allow for some regional flexibility in how ACOs operate, to allow them to adapt to local needs and environments. This flexibility should occur within general structure and guidelines, but allow for local differences.
- Use robust data collection and analyses, and standardized measures: States have found that it is important to have standard performance measures across ACOs and providers, and to use these to establish effective payment incentives. It is important to have strong data analytic capabilities which allow providers and ACOs to quickly assess their performance, and for the state to use the data and reports to assess the impact of incentives.
- Leverage cross-department resources: States have found that it is important to work closely with departments and agencies that focus on mental health and substance use

disorder services, public health, and other agencies to share knowledge and expertise and to pool resources.

- Convene and educate stakeholders: States have found tremendous value in engaging stakeholders, and in keeping them engaged throughout implementation and evaluation. Stakeholders can provide valuable input, and engaging them early and consistently can help build a stronger and more widely supported ACO model.
- Build on what exists: States have found that building an ACO model "from where they are" makes most sense. If a state uses a primarily fee for service structure, it makes sense to build an ACO from that, a structure above the provider level if you will. On the other hand, if a state already has managed care organizations, it may make sense to build ACOs underneath that structure.
- Integrate services: States have found that to truly transform delivery systems, a broad spectrum of services must be integrated, including primary care, specialty care, behavioral health, long term care supports and services, and community-based services. While it may not be possible to integrate everything at one time, it is important to have a plan in mind for integrating services over time.
- Think long term savings: States have found that it is important to think about generating savings as a long term endeavor. Most reforms take time to achieve improved health outcomes and reductions in cost.
- Integrate across systems: States are finding that it is important to try to align goals, performance measures, and payment reform activities across systems and payers, such as Medicare and commercial insurance. Doing so helps to avoid cost-shifting and helps ensure that all payers are working toward the same goals.

Workgroup Discussion Questions

Goals, Vision and Current State

1. What works well in the existing system as it relates to access to care, accountability, quality of care, and care coordination??
2. What does not work well in the existing system?
3. What should the priorities or goals be for the new system?
4. In five years, where do you want Iowa to be to consider this effort a success?
5. What are key components of a successful person-centered, integrated, accountable system?
6. How do we think about integrating LTCSS and BH services? How can contracting and/or metrics be used to help encourage more integration?
7. What are effective ways to engage individuals, including Medicaid members, in their health care?
8. What are the greatest potential barriers to achieving this person-centered, integrated, accountable system?

Leveraging Existing Structure

9. How should Iowa leverage existing structures?
10. How do those structures potentially need to change to meet Iowa's goals?

Financial and Measurement

11. How should such an ACO work financially?
12. What quality measures and patient satisfaction metrics should be in place?

IT Systems Needs

13. How would health information technology need to change to support integration?

Providers, ACOs, and Work Force Concerns

14. Are there adequate numbers of providers available across the state? Primary care and specialty?
15. What work force needs are there?

Work Group Suggestions

During the third and fourth workgroup meetings, members developed a series of suggestions regarding the approach to ACO contracting and suggested metrics and measures to use to evaluate performance and move the system to one that is value-based and that achieves the state's goals of lowering costs while improving quality of care and health outcomes. During the public comment period at the conclusion of every meeting, attendees also provided input and made suggestions.

During the third meeting, the workgroup developed a series of suggestions. The SIM team created a table of these suggestions and emailed the documents to the workgroup members; they prioritized the suggestions to support the SIM team in developing the SHIP. As part of the response to the SIM team, workgroup members also provided comments on the suggestions. To ensure each workgroup was aware of the suggestions generated by other workgroups, all four documents were sent to all the workgroup members.

This following table identifies the category of suggestion and comment; a summary of written comments and priorities received between the third and fourth Workgroup meetings, and the number r of members selecting as a priority (members ranked their top 3 suggestion). **In the final column, green boxes mean three or more people indicated as a priority; yellow boxes mean two people indicated as a priority; purple boxes mean one person indicated as a priority; and white boxes mean no member prioritized that suggestion.** It should be noted that not all workgroup members provided an indication of their priorities.

Category	#	Suggestions Captured from Metrics and Contracting Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
Data/ Transparency	1	The State should consider developing means to facilitate cost and data transparency (some states have developed an All Payer Claims Database (APCD)	1) There must be a recognition and understanding of the limitations of such data. Even when there are some measures of severity of condition, incidence of iatrogenic impacts, and cost as well as procedure. This is information alone is unlikely to be useful to consumers and likely starts the discussion/examination of value purchasing. As applied to specific procedures, it does not provide information on their medical necessity or address issues of variation in practice or procedure, which are of major importance. 2) There should be second recommendation: "Measures should include the ability for the state to provide meaningful and understandable data and information to patients, consumers and payers on the quality and cost of health provider performance."	

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			3) The purpose is to ensure data to coordinate care and share across all appropriate disciplines	
Regulatory/ Contractual Approach	2	While everyone should have a Patient Centered Medical Home, neither the State nor the ACO should specify and require a specific accreditation. The ACO contract should require that ACOs develop and implement strategies to simplify care coordination, with a goal of helping to ensure that each individual has a single "touch point" for care coordination.	The patient centered medical homes need to be constructed to address different populations and particularly recognize children's trajectories of healthy development; they need to be "family-centered" medical homes when dealing with young children. In determining how to develop family-centered medical homes that can achieve their objectives, the expectation for addressing social determinants/family concerns and issues needs to be built into the monitoring, financing, and support for those medical homes.	
Regulatory/ Contractual Approach	3	The State should not be overly prescriptive in terms of the how (no process definitions) care coordination, distribution of shared savings (with providers), etc. will occur, but should be prescriptive in terms of outcomes and expectations around cost savings and improved quality	1) The issue of "shared savings" requires projections of costs into the future and this requires very careful analysis, particularly as straight-line projections are likely to over-estimate costs. Where there are some identified ways to contain costs for specific populations (e.g. through reductions in readmission rates through care coordination and ancillary services), some of this should be factored into the work. At a minimum, some part of the "shared savings" that is expected to occur should not be shared with providers/ACOs but should be devoted to a "shared savings" pool to test more innovative and long-term strategies for achieving savings. 2) The State should identify specific outcomes expected. The entity identified as the contracted ACO should address its methodology to reach these outcomes through an RFP. The ACO should develop appropriate partnerships and strategies to achieve the aims utilizing	

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			regional partnerships most ready to innovate and deliver on the RFP. The partnerships may grow in number as maturation of the strategies evolve 3) Since this project is specifically intended for a Medicaid population, we wonder whether EPSDT Participation Rates would be a more appropriate metric than the more generalized Well-child visit metric. 4) The State should not be too prescriptive in rules and "hoops" to jump through regarding the specific model. The State should focus on "intent" and permit them to create a model that will work. Based on discussion, one member suggested the need to have some rules regarding adequacy of network, how they will engage the member (with a measure for member satisfaction), transitions of care issues especially in long term care and behavioral health. 5) Because proceeding into the "unknown" will take some creativity and ambition being overly prescriptive will likely hamper that creativity.	
Regulatory/ Contractual Approach	4	The State's contracts with ACOs should include language that ensures sufficient capacity for providing services in an aligned, integrated coordinated manner but they should not be overly prescriptive about identifying how or the specific groups or organizations.	Because the specific partnerships can and should vary by: region, readiness, and resources available within the geographic locations the State should permit and encourage the ACO to develop these relationships with entities they have identified as strong partners that will help them address community-needs. A top-down prescriptive model will not work well (address health equity issues) in many communities.	
Measures	5	There should be one Core Set of Measures for all payers	1) If this approach is taken there should be appropriate caveats on the degree to which these core measures can address questions related to cost, quality, access, and overall health outcomes. A little knowledge/information can be a dangerous thing. In addition, there need to be individuals/experts who both have statistical expertise and	

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			clinical expertise to be able to mine such data and measures in order to find areas of opportunity and points of disparity which require further investigation. In the health care field there is a shortage of bio-statisticians/researchers who can do the type of appropriate analysis of health databases to identify opportunities for reducing unnecessary utilization and identifying concerns regarding quality of care and iatrogenic impacts of treatment. 2) The core measure must be equally and appropriately weighted for all providers and partner types. Core measures as introduced through the VIS place all responsibility on primary care clinics with virtually no performance burden on the State or partnered entities, including those of third party administrators. To address this, the State should seek to utilize a few existing measures in reporting systems in such a manner that emphasizes the specific metrics most likely to decrease cost and improve outcomes. 3) This recommendation should be re-worded to say, "As a goal there should be one set of measures for all payers that provide meaningful and understandable information on quality and cost". 4) The one core set of measures should include measures for both chronic and acute illnesses. 5) Having one core set of measures will make it easier to manage and articulate what the measures mean and explain the results.	
Measures	6	The State should include in the Core Set of Measures, metrics that look at social determinants of health, especially for children and other special populations	1) In terms of simplification, there are metrics that should be incorporated into electronic medical records and that can be used for population-based analyses and comparisons. There are also metrics that should be incorporated into more detailed clinical records that can be analyzed as part of records review processes but themselves cannot be simplified for electronic medical records. These need to be developed and examined as complementary to one another, with what can be gleaned from each recognized. Under CHIPRA, there is work on EMRs, and the National Institute for Child Health Quality also is devoting	

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			significant efforts to this end. On clinical records and their review for very young children, there is very promising work going on under the Help Me Grow national replication project to incorporate information related to Bright Futures (evidenced-informed guidelines for the provision of well-child care) and the Strengthening Families framework. This also is part of 1st Five's work that deserves attention and support. 2) Several years ago in Iowa (through the Iowa Department of Public Health), there was work to design and test a patient-answered touch screen survey questionnaire at the birth of a child. This questionnaire gathered important information about both genetic and social determinants of health and also provided mothers with information about resources available to them based on their responses. This is deserves additional attention in development as a public utility, rather than something that should be left to individual ACO's/hospitals to develop as their own proprietary tools. 3) In addition, and particularly with respect to young children where strengthening families is essential, the outcome metrics will not be in terms of one discrete health condition, rather they will be measures as changes in health trajectories. 4) Since this project is specifically intended for a Medicaid population, it might be more appropriate to use EPSDT Participation Rates rather than the more generalized Well-child visit metric. 5) There should be one core set of quality measures for all payers. After participating in all workgroups, the recommendation should be broader and include language requiring that the measures are quantifiable, match national measures like HEDIS when possible, and have additional measures to reflect social determinants, member engagement and LTC. 6) These core set of quality measures needs to be at the center of measuring performance.	

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Measures	7	There should be additional metrics in the Core Set of Measures that address the LTC and BH needs of individuals.	1) LTC is very different from medical/acute services and measures and metrics can be more specific to meet individual needs. 2) These needs are very different and costly and should be monitored and articulated specifically.	
Financing	8	Any methodology for payment and/or calculation of scores needs to be risk-based or adjusted so as to create appropriate incentives to serve the most vulnerable populations.	1) The methodology should be risk-based/adjusted for the condition severity and also for variations in medical practice. 2) Payment methodologies should take into account the initial infrastructure investment required of ACOs. The fundamental differences between traditional managed care (utilization, process and referral management) and an integrated organized system of care for individuals and populations must be understood to fully advantage the long term success of the ACO. The State should recognize the ACO investment required; in the initial phases of the process should make an upfront fee with subsequent phase-in of risk-bearing ability as partnerships form. The administrative burden of managing participants should not shift directly to provider environments; rather, the State should stabilize the enrollment chronology. 3) There should be recognition of the need for risk based incentives to support caring for the most vulnerable/complex individuals. There should be recognition that these patients take more time both in face-to-face visits and in care coordination outside of visits. 4) The lack of appropriate incentives or the ability to adjust these as needed will hamper expansion of services in hard to reach locations and for individuals with higher needs.	
Access	9	The ACOs should support the use of telemedicine and telehealth to support and expand access	Requirements for expanded access need to account for the location of the provider and of the community needs and strengths. For example, individuals in some communities prefer morning appointments while in other communities the preference is for evenings. Also there should be recognition that not every community needs, and can support, weekend appointments. Tele-health as an option needs to be supported by the state professionally licensing bodies and accepted in Medicaid credentialing of	

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			providers.	
Patient Support	10	Information provided to patients needs to be delivered in a culturally and linguistically appropriate way and needs to be understandable to patients. In addition, there need to be additional measures of patient engagement for which ACOs are held accountable.	There should consideration for the costs and investments required by ACOs to develop materials and train their staff to support and encourage patients in changing their behaviors. There also is expense tied to translations and ensuring cultural competency requirements are met.	
Provider Support	11	Peer-to-peer learning is essential; need to create an environment around learning (Pioneer ACOs have done this). There was support for the idea of a transformation center that would help facilitate the sharing of ideas, successes and challenges, and that would help disseminate best practices and support ACOs and providers through the transition.	1) This is a tremendous opportunity for Iowa to foster and promote innovation and its diffusion through transparency and peer learning and to recognize that some of this innovation needs to occur at the frontline practice level by champions devoted to improved patient response (and not at the ACO level down by administrators focused on the bottom line). Some of this work deserves to be open-source, nonproprietary, and considered a public good. This is particularly important if the peer learning and innovations are developed through state funding and support. Some significant portion of federal resources secured for the implementation of the ACOs should be carved out to support innovation and its diffusion at the primary practice level, particularly for child populations where the gains are likely to be greatest over the long-term. These learning environments create opportunities for new partnerships and build on successes between regions. Through these activities, the State provides a learning venue and facilitates specific learning groups in activities such as management and reporting on metrics, programmatic successes and data management. 2) This peer learning and support should be provided at times and places convenient to providers.	
Provider	12	The State should require	Since ACOs are not employment specific entities, it does not appear to be	

Category	#	Suggestions Captured from Metrics and Contracting Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
Support		that ACOs re-train workforce to work in an environment that is focused on out-patient services rather than one that is focused on in-patient services.	appropriate to require them to re-train the workforce. However, this restructure and retraining may be part of the proposal.	

Additional Suggestions Received Outside of Workgroup Meetings
Using patent navigators for transitions of care, especially between inpatient and outpatient settings to improve outcomes and maintain the improvement gained in the hospital setting can help support members and providers. These individuals can be cross trained as health coaches. This hybrid model is not required but ACOs could be suggested or encouraged to implement this function.
The model should support openness and allow care to be provided in non-traditional settings such as community centers, Assisted Living facilities, patient homes, and other venues preferred by patients.
The technology needs to support communications across all providers.
Data transparency is important but should also reflect scoring for non-provider specific data such as risk scores of the patients (from health risk assessments and other data such as number of diagnoses or meds) as well as urban/rural practice sites, predominant age group, etc.
The ACOs must be sustainable and should be viewed as a way to develop an organized delivery system. They should be considered a tool in moving Iowa toward value-based and population-based health care.
The ACOs should develop and implement plans to provide care to children; these plans should include activities and functions that have demonstrated improvements in children's long term health trajectory.
The State should consider the idea of a “Community Reinvestment Fund” that will use a small percentage of shared savings to support innovations.
Medication management should be part of care coordination and the ACOs should be required to develop and implement plans to better coordinate and manage medications.

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